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HEALTH PLAN COST AND COVERAGE

Instructions: We recommend you buy a plan that minimizes overall annual costs if you have a major claim (Step 1), provides sufficient financial coverage (Step 2), allows you to see doctors you want (Step 3), and provides coverage as soon as possible (Step 4). Often the answers are in the fine print at the back of the health insurer's marketing brochure. If not there, call the insurer and ask for their answers in writing.

Health Plan Names. Write each plan name you are comparing.	1. _____	2. _____	3. _____
Step 1: Compare the overall annual costs			
Write the monthly premium. Premiums are the payment you make to purchase and maintain a health plan. You pay this amount even if you do not use services under a plan.	$_____	$_____	$_____
Calculate your annual premium. Use a calculator to multiply the monthly premium x 12. Write this amount.	$_____	$_____	$_____
Write the Out-of-Pocket Cap. The out-of-pocket cap is the most you will pay annually for services covered by the plan, but it does not include your premium. Some plans may call this cap a "maximum." *Note: Some plans don't count copayments towards the deductible or out-of-pocket cap. In that case your out-of-pocket expense may be higher than the cap. Check your plan for details.*	$_____	$_____	$_____
Calculate your overall annual cost. Add the Annual Premium to the Out-of-Pocket Cap. Write this amount. This amount is the total you will have to pay if you have a major claim.	$_____	$_____	$_____
Step 2: Compare coverage limits.			
Write the dollar limit on the plan's coverage, if any. Plans limit the benefits they will pay on a lifetime or illness basis, even if your own expenses are greater than this amount. These dollar limits can also be called maximums. We recommend plans with unlimited coverage. If there is a lifetime limit, it should be no lower than $2 million.	Lifetime: $_____ Illness: $_____	Lifetime: $_____ Illness: $_____	Lifetime: $_____ Illness: $_____
Step 3: Doctor selection and choice.			
Do I need to use the doctors on the plan's list? Some plans require you to use doctors from their provider network. If you use an out-of-network doctor, you may have to pay a higher co-pay, or even the entire cost of the service. Check your plan for details.	Yes or No or Yes, but at higher cost	Yes or No	Yes or No
Do I need a referral from my primary-care doctor to see a specialist? Some plans require you to get permission from a network primary-care doctor to see a specialist. This permission is called a pre-authorization.	Yes or No	Yes or No	Yes or No
Step 4: Exclusions and waiting periods.			
Write any excluded conditions. Write N/A is no exclusions. Plans may not cover certain medical conditions that you have.	_____	_____	_____
How long must I wait before I receive coverage under this plan? Write N/A if no waiting period. Plans may require a waiting period before coverage begins for a health condition you had prior to joining this plan (a preexisting condition). If Yes, write how long the waiting period.	_____	_____	_____

For more information about all your health needs, log on to http://www.consumerreports.org/health

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25 BENEFITS QUESTIONS TO ASK ABOUT EACH HEALTH PLAN

This form will help you decide if this plan has the benefits you need. Answer each question for each health plan you may buy. Use a separate sheet for each plan. Check "Yes" or "No" and list any limitation on the benefit in the "Details" column. Often the answers to these questions can be found in the fine print at the back of the health insurer's marketing brochure. Many "No" answers or benefit limitations may mean the plan is not right for you.

PLAN NAME:	Yes	No	Details
1. Does the plan cover the costs of a doctor visit even if you are not sick?			
2. Does the plan cover the costs of immunizations (shots) ?			
3. Does the plan cover the costs of tests (mammograms/colorectal cancer tests/PAP smears)?			
4. Does the plan apply the coinsurance to the providers' actual price for the service?			
TIP: If you pay coinsurance, find out if the coinsurance rate is applied to the provider's actual charge or to what the insurer calls a "usual, customary, or reasonable" (UCR) or negotiated price for the service. If the provider's price is higher than the UCR price, you may have to pay the difference between the two prices, in addition to the coinsurance.			
5. Does the plan cover the cost of eye exams? If so, how often?			
6. Does the plan cover the cost of eyeglasses and contact lenses? If so, how often?			
7. Does the plan cover mental health visits?			
8. Does the plan limit the number of mental health visits per year? If so, how many?			
9. Do the mental health visits have to be within a specified time period? If so, how often?			
10. Does the plan cover the costs of acupuncture or chiropractic treatment? If so, how often?			
11. Does the plan cover the costs of dental checkups and treatment? If so, how often?			
12. Does the plan cover the costs of maternity care?			
TIP: If you have a single person's health plan, purchase a "family" plan before the baby is born so that the baby is covered by your insurance after birth.			
13. Does the plan cover the cost of prescription drugs?			
14. Is there a separate prescription drug deductible? If so, what is it?			
15. Does the plan limit what events or accidents qualify as emergencies?			
TIP: Some plans define the term "emergency" as a life-threatening condition that cannot be treated by your doctor. Using this definition, the plan may deny emergency-room treatment for a broken arm because it is not life threatening. See how this plan defines a "medical emergency," an "accidental injury," and treatments that are "medically necessary." The plan may not provide the same coverage under all three circumstances.			
16. Does the plan allow you to choose your hospital if you need surgery?			
17. Does the plan cover the cost of physical therapy if you need to recuperate?			
18. Does the plan limit the number of office physical therapy visits per accident?			
19. Must the physical therapy visits be within a specified time period following the accident?			
20. Does the plan pay for a second opinion?			
21. Does the plan cover experimental or investigational treatments?			
22. Is there an appeals process available if the plan refuses to pay for a treatment?			
TIP: For each medical condition (e.g., allergies, asthma, diabetes, high cholesterol, or high blood pressure) that you, or a family member covered by this plan have, answer the next 3 questions			
23. Does the plan limits the number of doctor visits to treat this condition per year? If so, how many?			
24. Does the plan make you wait a specific number of days before seeing the doctor again about the same condition? If so, how many?			
25. Does the plan cover expenses for supplies, such test strips and inhalers?			